FAMILY AND MEDICAL LEAVE NOTIFICATION

Date: _____

TO: _____ _____
Employee Name Classification

_____
Street Address

_____
City, State & Zip Code

You notified us of your need to take leave. This memorandum is to notify you that:

1. ☐ You are eligible for leave under FMLA.

2. ☐ You are being placed on FMLA
OR

You are being tentatively placed on FMLA, pending receipt of the appropriate documentation due to the following reason:

- ☐ the birth of a child
- ☐ the placement of a child for adoption or foster care
- ☐ your own serious health condition
- ☐ a serious health condition affecting your:
  - ☐ spouse
  - ☐ child
  - ☐ parent for which are needed to provide care.

3. ☐ This leave ☐ may ☐ will be counted against your FMLA entitlement and will begin/began on _____. You have indicated that you expect this need for leave to continue until, on, or about _____.

Provided you comply with the conditions listed below, you have a right under the FMLA for up to 12 workweeks of leave in a 12-month period for the reason indicated above. You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave.

4. ☐ You must furnish medical certification of a serious health condition by _____ (Medical Certification forms are attached for your physician's use.)
(date)

5. ☐ You must first use your available paid leave balances for FMLA leave. Leave without pay (LWOP) will only be granted after you have exhausted your paid leave (annual, sick or straight compensatory balances). If LWOP is used, YS shall continue to pay the employer and employee's share of the insurance premiums, but the employee will be required to pay back to the agency the employee's share of those premiums upon returning to work.
   a. Upon my return to work, I agree to repay the employee share of my insurance premiums that YS paid while I was on FMLA/LWOP.

      _____
      (employee signature)

   b. I will send payments to YS for the employee share of my monthly insurance premiums while I am on FMLA/LWOP. (Check must be made payable to Youth Services.)
      NOTE: If payment is not received, Recoupment process will start upon employee returning to work.

      _____
      (employee signature)

6. ☐ For leave due to:
   your own serious health condition
   pregnancy complications or
   a chronic condition
   you are required to furnish recertification from your health care provider as follows:
7. ☐ For leave due to a family member's serious health condition, you are required to furnish recertification from the family member's health care provider.
8. ☐ You are required to present a fitness-for-duty certificate prior to being restored to employment.
9. ☐ While on leave, you are required to furnish us with periodic reports every 30 calendar days of your status and intent to return to work.
10. ☐ Comments regarding FMLA request or issues:

_____	_____
COHR Signature	Unit Head's Signature
_____	_____
COHR Name (Print or Type)	Unit Head's Name (Print or Type)
_____	_____
Street Address (to return forms to)	Date
_____	
City, State & Zip Code	